Introduction

Cognitive-Behavioral Therapy: Efficacy and Applications

By Edna B. Foa, PhD, and Martin E. Franklin, PhD

It has been a pleasure to assemble this month’s issue of CNS Spectrums about cognitive-behavioral therapy (CBT) for anxiety disorders in which the successful treatments of five disorders are discussed. As is evident from the five papers in this issue, most patients with pathologic anxiety can be helped with available treatment, either short-term CBT or medication. Also apparent in these papers is that the work has not been completed: some patients do not benefit from the available treatments at all, and most who do respond still remain somewhat symptomatic.

The paper by Patricia A. Resick, PhD, and colleagues presents data that bear on a highly controversial issue among experts in posttraumatic stress disorder (PTSD), namely the relevance of short-term CBT for complex PTSD. The results of the paper support the hypothesis that individuals with a history of child sexual abuse do portray a more complex symptom profile than those without such a history. However, both cognitive processing therapy and prolonged exposure were highly and similarly effective with patients with and without child sexual abuse histories. Thus, these results do not support the widely held belief that short-term CBT programs are ineffective with complex PTSD.

Nadine Recker Rayburn, MA, and Michael W. Otto, PhD, eloquently summarized the outcome literature on panic disorder and agoraphobia, within a theoretical context that explains the maintenance of panic symptoms as embedded in misinterpretation of physiologic sensations and avoidance of situations that are likely to give rise to these sensations. All CBT treatments for panic include exposure and cognitive elements. Some programs emphasize exposure exercises while other focus on formal cognitive-therapy techniques that involve exposure in the form of behavioral experiments. The authors note that at least 74% of patients in CBT programs are panic free at posttreatment and 50% achieve status of high endstate functioning. These gains are generally maintained after discontinuation of treatment. Pharmacotherapy with benzodiazepines and antidepressants produce generally comparable acute outcome to that of CBT. However, while CBT is more costly than medication during the acute treatment phase, by 1 year its cost is half that of medication. Second, combining medication and CBT may enhance the efficacy of CBT in the short run but reduces its efficacy in the long run. Third, many patients relapse upon discontinuation of medication, but adding CBT during the discontinuation phase protects patients from such relapse.

Elizabeth A. Hembree, PhD, and colleagues summarize results on long-term outcome of exposure and ritual prevention (EX/RP) alone, pharmacotherapy alone, and combined treatment with obsessive-compulsive disorder (OCD). Hembree and colleagues use this platform to present an insightful discussion about future directions in research on OCD. Three conclusions can be drawn from the data. First, each of the treatments produced lasting benefit as long as patients remained on medication. Second, CBT is quite effective and durable with OCD, as 70% of patients receiving EX/RP were responders about 2 years posttreatment discontinuation. Third, EX/RP appears to be superior to pharmacotherapy alone when both treatments were discontinued.

James P. Hambrick, MA, and colleagues have produced a comprehensive summary of the status of CBT with social anxiety disorder within the context of a theoretical model that emphasizes a complex interplay between dysfunctional cognitions, physiologic symptoms, and behaviors, some of which influence audience responding. Three main conclusions emerged from the paper. First, due the nature of the disorder, exposure to social situations is central to all CBT packages, which on the whole are more effective than control comparison conditions, such as educational support. Second, as with panic disorder, medication has found to be equally effective to CBT at posttreatment, but relapse upon treatment discontinuation is common in the former but not the latter. Third, irrespective of the specific CBT package, reduction of dysfunctional cognitions predicts degree of improvement. Yet, the addition of formal cognitive restructuring does not enhance the efficacy of exposure alone. This may be because during exposure to social situations cognitive distortions are addressed either directly or through disconfirmation of anticipated negative consequences.

Thomas D. Borkovec, PhD, and colleagues present an excellent exposition of theoretical considerations about the nature and function of worry in generalized anxiety disorder (GAD). In it, they connect theory with treatment development. The authors point out that worry is conceptualized as a form of cognitive strategy that patients invoke in order to prevent envisioned future catastrophes and to avoid dealing with emotionally valenced material of an interpersonal nature. Compared with the successful outcomes of CBT with other anxiety disorders, the success in GAD is more limited. The authors suggest that this is partially due to the difficulties in pinning down the diffuse fears and worries that characterize GAD. Third, the somewhat limited outcome and the difficulties in addressing GAD via traditional exposure methods require novel treatment approaches.

The five papers in this issue present a comprehensive review of the effectiveness of CBT in ameliorating symptoms of anxiety disorders. We recognize that the readers of CNS Spectrum are already knowledgeable about the usefulness of pharmacotherapy for these disorders. We therefore wish to thank the editor, Dr. Jack Gorman, for providing this forum to familiarize physicians and clinicians with the efficacy of CBT. Our patients will greatly benefit from interdisciplinary initiatives like the one undertaken here.